3 VULNERABLE POPULATIONS

Medicare was enacted in 1965 to help the elderly satisfy their acute health care needs, and expanded in 1972 to include persons under the age of 65 who meet certain disability criteria or have chronic kidney disease. The success of the program is often measured in terms of its ability to provide all segments of the Medicare population with equitable access to health care (Long and Settle, 1984). While the program has substantially reduced barriers to care, some segments of the Medicare population remain at risk of not having access to needed medical care. The at-risk groups include the oldest old, racial and ethnic minorities, functionally disabled beneficiaries, low-income groups, and beneficiaries who do not have supplemental insurance. These groups are considered vulnerable because they may encounter greater problems, and have fewer alternatives, in acquiring care than other beneficiaries (Trude and Colby, 1997).

This chapter focuses on vulnerable populations residing in household units (i.e., community settings). It includes a description of the vulnerable groups and measures of their ability to obtain medical care in 1995. Some of the measures of access are relatively objective, while others are subjective. An objective measure, such as the amount of care received during a year, can be used to determine whether a vulnerable group is having relatively more difficulty than another group of beneficiaries in obtaining health care. Subjective measures of access also are provided because some vulnerable groups may have an underlying problem with access to needed services even though they are already using more services than other groups (Moy and Hogan 1993). The subjective measures of access include beneficiaries' satisfaction with the availability, quality, and cost of health care, and whether they have a usual source of care.

Most of the groups included in this chapter have been followed closely in recent years because of concern that the Medicare Fee Schedule, which significantly changed payments for physicians' services starting in 1991, would adversely affect access to care by some Medicare beneficiaries (Physician Payment Review Commission, 1996). Access by vulnerable populations will continue to be an issue, moreover, as the Medicare program continues to evolve. The Balanced Budget Act (BBA) of 1997, for example, contains provisions affecting almost every aspect of Medicare (Medicare Payment Advisory Commission, 1998). Changes legislated by the BBA are intended to reduce Medicare program costs and allow beneficiaries to participate in a wide variety of managed care arrangements. However, some of the changes could have unintended consequences for vulnerable segments of the Medicare population.

The Oldest Old

Beneficiaries age 85 years and older are considered to be vulnerable because they have significantly greater health care needs than younger Medicare beneficiaries. The aging process makes them more likely to have functional limitations or cognitive impairments, and less able to care for themselves. Moreover, as poor or deteriorating health heightens their demand for health care, mobility limitations may become a barrier to some types of care such as ambulatory services (Long and Settle 1984).

About 8 percent of all Medicare beneficiaries living in communities are at least 85 years of age. Two-thirds of them are female, and nearly one-half of them live alone. Beneficiaries in this age group probably do not have significant financial barriers to care. Sixty-five percent of the oldest old have supplemental private health insurance, 17 percent have Medicaid coverage, and another 9 percent are enrolled in Medicare health maintenance organizations (HMOs). Moreover, their incomes are not remarkably lower than that of other younger beneficiaries, averaging $13,318 for single beneficiaries and $27,840 for married beneficiaries.

Figure 3-1 contains data showing the extent to which the aging process affects older populations. Differences in functional status are most notable in comparisons of the oldest old with relatively

young beneficiaries in the 65-74 age group. The oldest old are 23 percent more likely to have two or more chronic conditions, 152 percent more likely to have at least one functional limitation, 121 percent more likely to have a mobility limitation, and 112 percent more likely to have a social activity limitation.[1]

The differences in health status and functioning suggest that the oldest old require more health care than their younger counterparts, but they may have to overcome more difficulties to obtain care. Figure 3-2, which shows the proportion of elderly community residents by age category and share of personal health care expenditures, confirms the propensity of beneficiaries to use more health care as they grow older. The oldest old had average health care expenditures of $8,214 per person in 1995, while beneficiaries in the 65-74 and 75-84 age categories had average expenditures of $5,241 and $6,887, respectively.

Per person health care expenditures by the oldest old exceed expenditures in the 65-74 and 75-84 age groups by 57 percent and 19 percent, respectively. The differences in spending highlight a tendency for health care expenditures to increase with age, but they do not answer the question of whether the oldest old have adequate access to medical care. Current levels of use could mask the need for additional care; conversely, they could include expenditures on inappropriate or unnecessary care.

Other measures of access suggest that the oldest old are no more likely than beneficiaries in the 65-74 age group to encounter barriers to care. The data in Figure 3-3, for example, show how beneficiaries describe their own access to care. The oldest old are no more likely to have difficulty in obtaining care, and they are less likely to delay care due to cost or not see a doctor about a problem. Moreover, the oldest old are as likely as younger beneficiaries to have a usual source of care.

Figure 3-1 Proportion of Community Residents with Chronic Conditions and Limitations, by Age Group, 1995

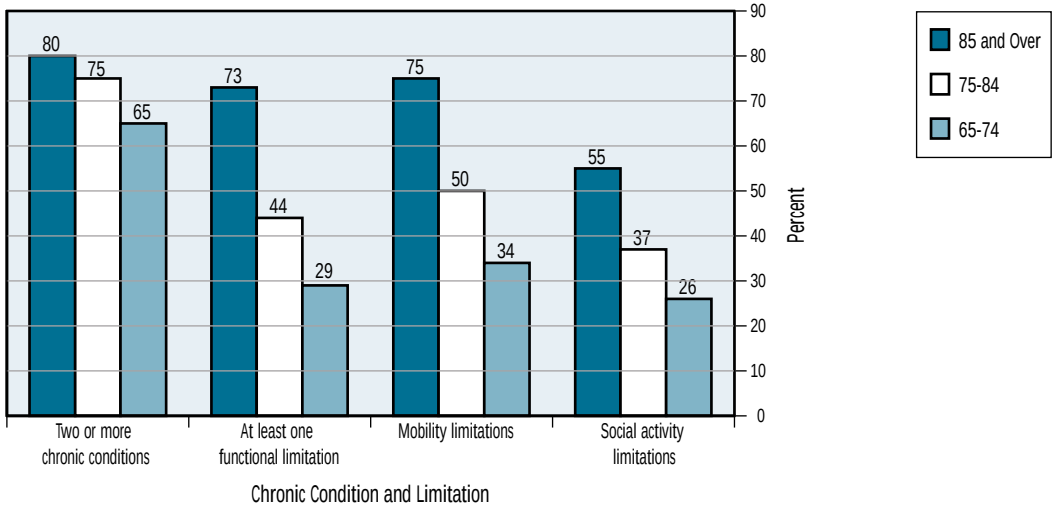
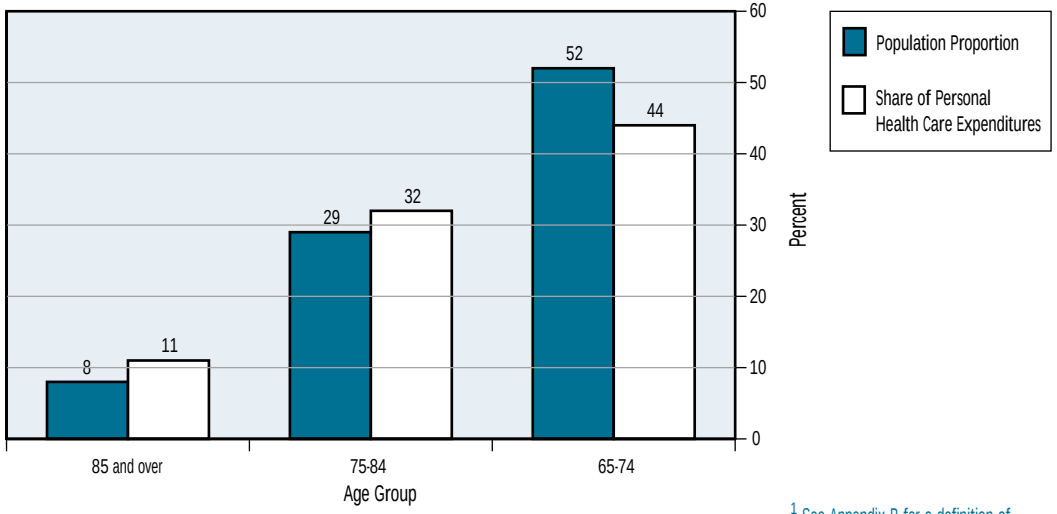
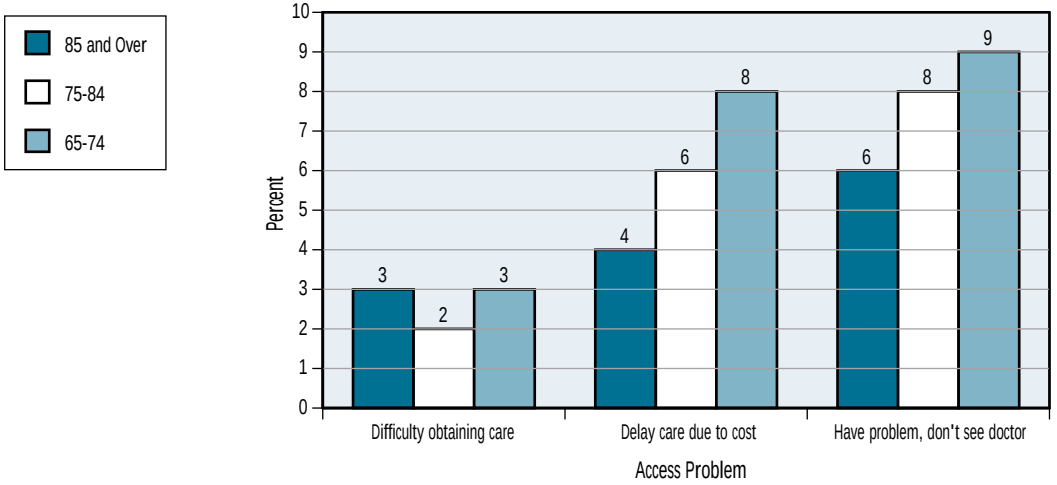


Figure 3-2 Distribution of Personal Health Care Expenditures of Community Residents, by Age Group, 1995



[1] See Appendix B for a definition of activities of daily living and mobility limitations.

Figure 3-3 Proportion of Community Residents Reporting Access Problems, by Age Group, 1995



Racial and Ethnic Minorities

Studies of the elderly show that blacks and Hispanics have higher rates of functional limitations and lower life expectancies than whites in the same age categories (U.S. Bureau of the Census, 1996). Access to health care is an issue for minority beneficiaries because Medicare, despite its universality of coverage, does not guarantee health care commensurate with need. Potential barriers to care for blacks and Hispanics, for example, include income inequalities, lack of supplemental insurance, shortages of health professionals, racial discrimination, language barriers, and cultural attitudes about the use of health care (Trude and Colby, 1997).

In 1995, about 9 percent of all Medicare beneficiaries living in communities were non-Hispanic black, and 6 percent were Hispanic. Figure 3-4 provides an indication of their self-reported health status relative to non-Hispanic whites. Non-Hispanic blacks and Hispanics were significantly more likely than non-Hispanic whites to report that they were in poor or fair health. Functional limitations also are more prevalent among racial and ethnic minorities. They were more likely to have at least one activity of daily living limitation, and less likely to have no mobility limitations.

Because self-reported health status is a good predictor of the need for health care (Blendon et al., 1989), blacks and Hispanics should be expected to consume more health care than whites in the absence of barriers to care. The ability of a beneficiary to satisfy his or her need for health care is determined in part, however, by factors such as income, supplemental health insurance, and presence of a usual source of care. These factors may limit access to care by blacks and Hispanics relative to whites. The data in Figure 3-5, for example, show that blacks and Hispanics have about 60 percent of the average income of whites. In addition, the minority groups are significantly less likely to have supplemental insurance, or use a physician in an office, clinic, or HMO as their usual source of care.

In 1995, the average health care expenditure by whites was $6,038, compared with $7,656 for blacks and $6,135 for Hispanics. Per capita spending by Hispanics and whites was essentially the same, even though Hispanics were reporting far more health problems.

Figure 3-4 Health Status of Community Residents, by Race and Ethnicity, 1995

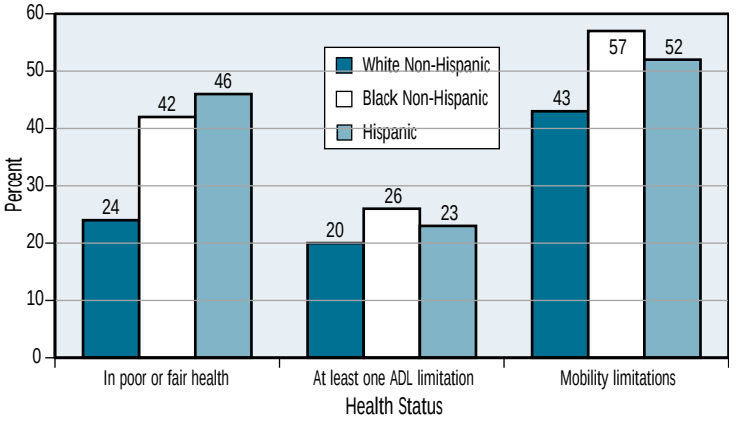


Figure 3-5 Per Capita Income of Community Residents, by Marital Status and Race/Ethnicity, 1995

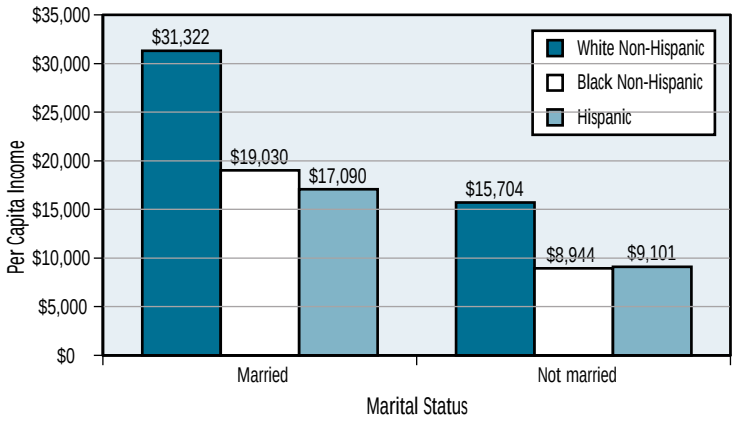
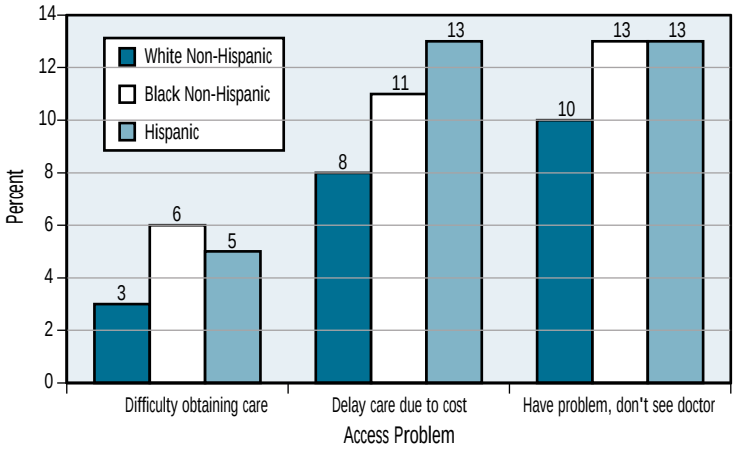


Figure 3-6 Proportion of Community Residents Reporting Access Problems, by Race/Ethnicity, 1995



Blacks, on the other hand, spent about 27 percent more on health care than whites. The higher level of spending is consistent with the greater prevalence of problems reported by blacks, but it could mask problems with access to care. These problems are highlighted in Figure 3-6, which shows the proportion of beneficiaries, by race and ethnicity, reporting difficulty in seeing a physician during the past year.

Blacks and Hispanics reported more problems than whites in obtaining care. Six percent of the blacks and 5 percent of the Hispanics said they had difficulty getting care, compared with 3 percent of the non-Hispanic white beneficiaries. The two minority groups also were more likely to delay seeking care for cost reasons (11 percent of blacks and 13 percent of Hispanics, compared to 8 percent of whites). Moreover, they were also more likely to have a health problem and not consult a doctor (13 percent of blacks and Hispanics, compared to 10 percent of whites).

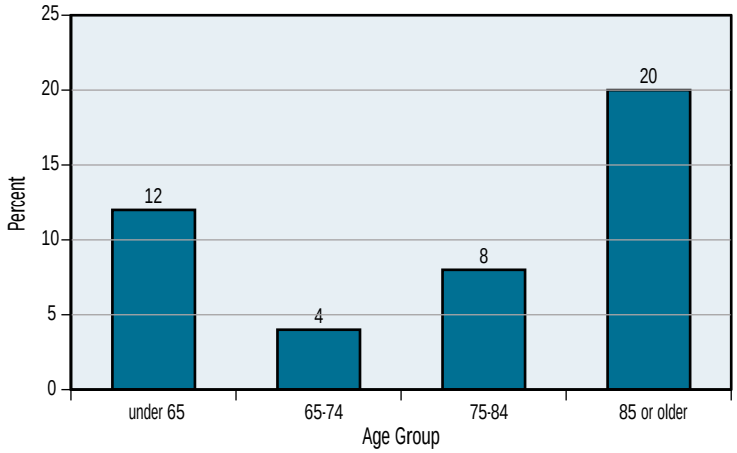
The Functionally Disabled

Functionally disabled beneficiaries are vulnerable because their health problems create a continuing need for medical care and assistance in performing activities of daily living (Trude and Colby, 1997). In this chapter, a beneficiary is considered functionally disabled if he or she has three or more activity of daily living limitations. Seven percent of the community residents met this definition in 1995, and nearly all of them had related health problems. Ninety-seven percent of them had mobility limitations, 88 percent had social activity limitations, and 91 percent had two or more chronic conditions.

Functionally disabled beneficiaries are not representative of other beneficiaries in terms of gender or age. Sixty-four percent of them are female, compared with 55 percent of other beneficiaries living in communities. Figure 3-7 shows the proportion of functionally disabled beneficiaries relative to other community residents by age category. Twelve percent of the beneficiaries under the age of 65 and 20 percent of the oldest old are functionally disabled.

The cost of health care may affect functionally disabled beneficiaries more than most other beneficiaries. In 1995, the average

Figure 3-7 Proportion of Community Residents Who Are Functionally Disabled, by Age Group, 1995



income of functionally disabled beneficiaries who were married was 17 percent less than that of other beneficiaries ($24,875 vs. $29,932), and single beneficiaries had 19 percent less income ($11,756 vs. $14,569). Moreover, 15 percent of the functionally disabled did not have supplemental insurance.

Figure 3-8 Proportion of Community Residents Using Hospital Services, by Functional Status, 1995

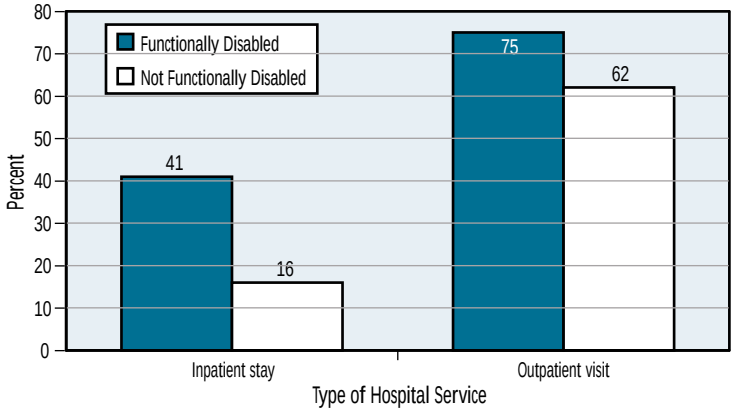
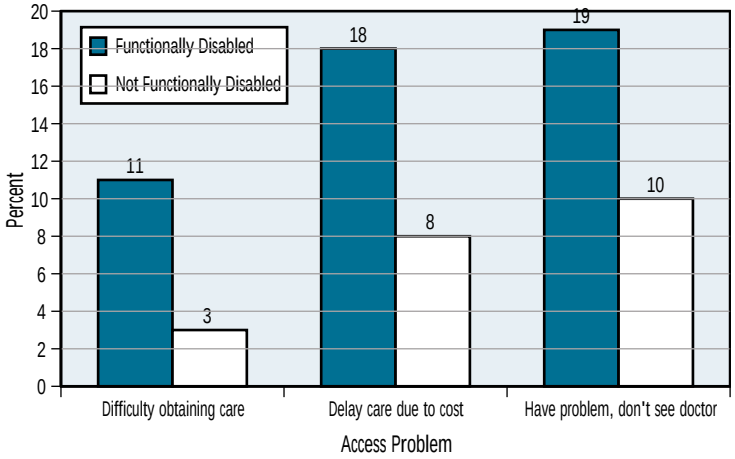


Figure 3-9 Proportion of Community Residents Reporting Access Problems, by Functional Status, 1995



Income and supplemental insurance are concerns for the functionally disabled because they require significantly more health care than other beneficiaries. The average expenditure by a functionally disabled beneficiary was nearly 3 times higher than that of other Medicare beneficiaries living in communities in 1995 ($15,846 vs. $5,418). Much of the difference is driven by the use of hospital services. In 1995, for example, functionally disabled beneficiaries were 156 percent more likely to have at least one inpatient hospital stay, and 21 percent more likely to need outpatient hospital care (see Figure 3-8).

Access to care appears to be a problem for the functionally disabled. Even though 95 percent of them have a usual source of care, they are much more likely than other beneficiaries to have problems obtaining care (see Figure 3-9). Eleven percent of the functionally disabled had difficulty obtaining care during the past year, 18 percent delayed care due to cost, and 19 percent had a medical problem but did not see a doctor. The underlying reasons for the number of beneficiaries reporting difficulty in obtaining care are undoubtedly complex, but out-of-pocket cost may be a key factor. Married

beneficiaries spent about 9 percent of their combined incomes on health care for the disabled spouse, while single beneficiaries spent about 20 percent of their income on personal health care.

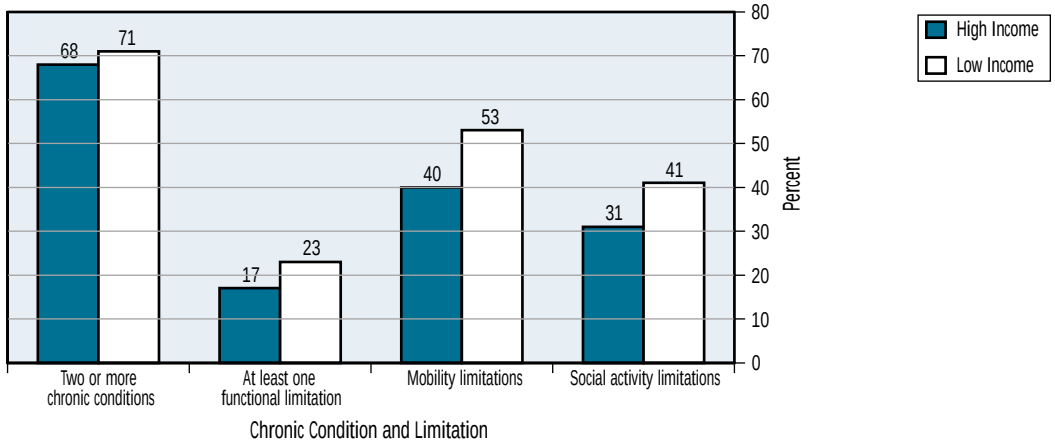
Low-income Beneficiaries

Low-income Medicare beneficiaries are another potentially vulnerable population. These beneficiaries are in worse health and have more limitations in activities of daily living than high-income beneficiaries (Olin and Liu, 1998). Whether they have problems obtaining access to care is less clear. Some studies indicate that income-related disparities in access to care by Medicare beneficiaries had largely disappeared by the early 1980s (Link et al., 1980; Long and Settle, 1984). However, more recent studies suggest that income may affect access to care by Medicare beneficiaries (Mentnech et al., 1995; Trude and Colby, 1997).

The low-income beneficiaries described in this chapter include community residents who were not covered by Medicaid, but had incomes below 120 percent of the Federal poverty level (FPL).[2] Some of these beneficiaries may qualify for Medicaid or the Specified Low-Income Medicare Beneficiary (SLMB) even though they do not participate.[3] Others may have assets that exceed the limits for Medicaid or other assistance for low-income beneficiaries. In 1995, slightly more than one of seven community residents (15 percent) was in the low-income group. Average income was $6,340 for single beneficiaries and $7,622 for married beneficiaries. In contrast, the average income of single and married beneficiaries who had incomes greater than 120 percent of the FPL (i.e., "high-income" beneficiaries) was $20,338 and $33,594, respectively.

Per capita health care spending by low-income beneficiaries was $5,650, or 5 percent less than spending by high-income beneficiaries in 1995. The difference in health care spending may be less than warranted by the relative health status of the two groups (Figure 3-10). The prevalence of chronic conditions is about the same for the two groups, but low-income beneficiaries are more likely to have functional limitations (23 percent), mobility limitations (53 percent), and social limitations (41 percent). These differences in health also are reflected in beneficiaries' assessments of their health. Only 37 percent of the low-income beneficiaries said they were in excellent or very good health, compared to 49 percent of the high-income beneficiaries.

Figure 3-10 Proportion of Community Residents with Chronic Conditions and Limitations, by Income Group, 1995

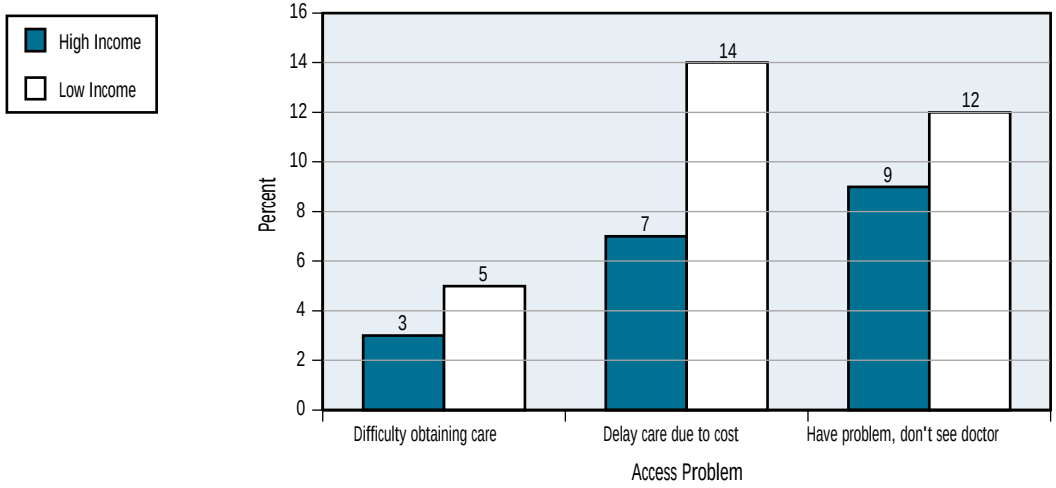


Out-of-pocket cost may affect access to care by the low-income beneficiaries relative to their wealthier counterparts. Low-income beneficiaries live on tight budgets, and many of them do not have supplemental insurance to help defray the cost of their health care. In 1995, for example, 30 percent of the low-income beneficiaries did not have supplemental private insurance, compared to 10 percent of the high-income beneficiaries. These differences in income and insurance coverage may contribute to the prevalence of problems reported by low-income beneficiaries in gaining access to medical care (Figure 3-11). In 1995, the proportion of low-income beneficiaries who had difficulty in obtaining care during the previous year, delayed care due to cost, or had a problem but did not see

[2] In 1995, the Federal poverty level was $7,309 per year for a single beneficiary and $9,219 for a married beneficiary age 65 or older.

[3] The latter program requires states to pay the Medicare Part B premium for beneficiaries with incomes between 100 and 120 percent of the Federal poverty level. Beneficiaries with incomes below the Federal poverty level, on the other hand, may be eligible for additional benefits through Medicaid.

Figure 3-11 Proportion of Community Residents Reporting Access Problems, by Income Group, 1995



a doctor, was significantly higher than reported by high-income beneficiaries.

Fee-for-service-only Beneficiaries

Fee-for-service-only refers to beneficiaries in the traditional Medicare program who do not have supplemental insurance. These beneficiaries must pay deductibles and copayments for acute care services provided under Part A and Part B of Medicare. They are also responsible for the full cost of noncovered services such as nursing home care, prescription medicines, and dental and vision care.

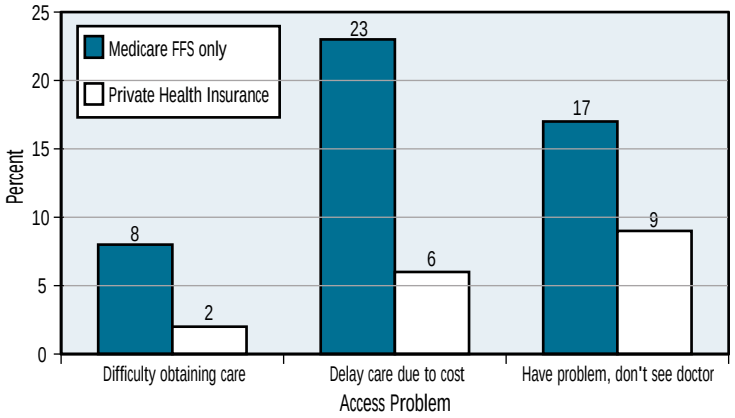
Medicare cost sharing liability is intended to dampen the use of acute care services, but its impact on health care spending is limited. Most beneficiaries living in communities have supplemental insurance through Medicaid or private sources, or they belong to HMOs. The cost of health care is not considered to be significant for these beneficiaries. Fee-for-service-only beneficiaries, on the other hand, may forego care because deductibles and copayments for Medicare-covered services are an out-of-pocket expense. These beneficiaries are at risk of not having access to needed medical care.

In 1995, 11 percent of the community residents were fee-for-service-only beneficiaries. Their average expenditure on health care was $5,011, compared to $6,081 for beneficiaries with private supplemental insurance. Comparisons are complicated, however, by the effects of health insurance on the consumption of health care. Medicare beneficiaries with supplemental insurance consume more health care than fee-for-service-only beneficiaries (Wolfe and Goddeeris, 1991). One possible explanation for the additional consumption is that supplemental health insurance reduces the marginal cost of health care and induces the consumption of more care (moral hazard). In addition, beneficiaries who anticipate high medical expenditures have greater incentive to purchase insurance (adverse selection).

Although conventional theory suggests that supplemental insurance should stimulate expenditures on health care, the empirical evidence is not conclusive (Trude and Colby, 1997). Fee-for-service-only beneficiaries could consume less health care than beneficiaries with supplemental insurance because access is a problem. The data in Figure 3-12, for example, show large differences in the numbers of fee-for-service-only beneficiaries reporting access problems compared with beneficiaries who had supplemental private insurance in 1995. They were approximately 4 times as likely to report difficulty in getting care in the previous year or to delay care due to cost, and nearly twice as likely to have a medical problem but not see a doctor. Moreover, 14 percent of the fee-for-service-only beneficiaries did not have a usual source of care, compared with 6 percent of the beneficiaries who had supplemental private insurance.

The fee-for-service-only population also is composed largely of beneficiaries who might be considered vulnerable for other reasons. Twenty-eight percent of the group is non-Hispanic black or

Figure 3-12 Proportion of Community Residents Reporting Access Problems, by Health Insurance, 1995



Hispanic, compared with 6 percent of the beneficiaries who had private supplemental insurance. Fifty-three percent had less than 12 years of education, compared with 32 percent of those with private supplemental insurance.

Summary

Although Medicare has been remarkably successful in providing the elderly and disabled with access to health care, some Medicare beneficiaries still have difficulty in obtaining care. These beneficiaries often are classified as vulnerable based on individual characteristics such as predisposing factors, enabling influences, and need for health care (Aday and Anderson, 1981). The factors tend to facilitate grouping of vulnerable beneficiaries into populations such as the ones used in this chapter—the oldest old, racial and ethnic minorities, functionally disabled, low-income beneficiaries, and fee-for-service-only beneficiaries.

In one sense, the groupings provide misleading information on the extent to which access to care is a problem. Each group contains a relatively small number of beneficiaries, overlap between groups is considerable, and not all beneficiaries in a group are vulnerable. In another sense, the groupings are extremely useful. Group characteristics can be used to identify pockets of beneficiaries where utilization, access to and satisfaction with care, and presence of a usual source of care seem less than adequate relative to other groups.

From the latter perspective, all of the vulnerable populations except the oldest old seem to have notable access problems. Racial and ethnic minorities, low-income beneficiaries, and fee-for-service-only beneficiaries have relatively low expenditures given the prevalence of health problems within these groups; and the proportion of beneficiaries reporting difficulty in obtaining medical care seems high. Functionally disabled beneficiaries, on the other hand, have relatively high expenditures, but they report more access problems than any group except fee-for-service beneficiaries.

Moreover, while the oldest old appear to have better access to care than other vulnerable groups, some beneficiaries in this group may have access problems. In 1995, beneficiaries in poor health were almost 3 times as likely as their healthier counterparts to report difficulty in obtaining care during the past year. Beneficiaries with three to five ADL restrictions were twice as likely to delay care due to cost. Medicare fee-for-service-only beneficiaries were twice as likely to have difficulty in obtaining care, and 3 times as likely to delay care due to cost. Beneficiaries who have both functional and mobility limitations were 3 times as likely as those with no limitations to have difficulty obtaining health care. These beneficiaries constitute a small proportion of the oldest old, but they may have problems with access to care.